

Wisconsin Department of Regulation & Licensing

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Madison, WI 53703
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Website: <http://www.drl.state.wi.us>

EMPLOYMENT VERIFICATION FORM **FOR EMPLOYERS OTHER THAN HOSPITALS**

MEDICAL EXAMINING BOARD

IMPORTANT: PLEASE FORWARD THIS FORM TO ALL EMPLOYERS DURING THE LAST 5 YEARS (This form may be photocopied).

The **State of Wisconsin** requests that you complete this form concerning the following individual:

PHYSICIAN'S NAME: _____

EMPLOYER'S NAME: _____

EMPLOYER'S ADDRESS: _____

EMPLOYER'S TELEPHONE: _____

1. What position did this physician hold when employed by you? _____

2. What were this physician's dates of employment? _____

- | | <u>YES</u> | <u>NO</u> |
|--|--------------------------|--------------------------|
| 3. Did this physician leave your employ in good standing?
If no, please attach explanation on a separate sheet. | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Was the physician on probation, suspended or in any way sanctioned/disciplined while employed by you?
If yes, please attach explanation on a separate sheet. | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Was this physician granted a leave of absence while employed by you?
If yes, please attach explanation on a separate sheet. | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Were any restrictions or special requirements placed on this physician's activities which were not placed on all other employees holding similar positions?
If yes, please attach explanation on a separate sheet. | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Was this physician denied hospital privileges while employed by you?
If yes, please attach explanation on a separate sheet. | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Were any restrictions or special requirements placed on this physician's hospital privileges?
If yes, please attach explanation on a separate sheet. | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Were any formal patient or staff complaints filed against this physician?
If yes, please attach explanation on a separate sheet. | <input type="checkbox"/> | <input type="checkbox"/> |

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YES **NO**

10. Were any incident reports filed involving the professional conduct or behavior of this physician?

☐ ☐

If yes, please attach explanation on a separate sheet.

11. Was this physician ever subject to a non-routine monitoring while in your employ?

☐ ☐

If yes, please attach explanation on a separate sheet.

12. Was this physician removed from a call schedule for cause?

☐ ☐

If yes, please attach explanation on a separate sheet.

Print name of Employer Supplying Information _____

Signature of Employer Supplying Information _____

Date form was completed _____

PLEASE ATTACH LETTERHEAD FROM THE FACILITY WHERE THE APPLICANT WORKED OR SUPPLY SOME FORM OF IDENTIFICATION FOR INDIVIDUAL SUPPLYING INFORMATION.

Please return directly to:

Department of Regulation and Licensing
Medical Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935